AmeriHealth Inc./AmeriHealth HMO and United Food & Commercial Workers Union, Local 56, AFL-CIO, Petitioner. Case 4-RC-19260

August 27, 1998

DECISION ON REVIEW, DIRECTION, AND ORDER REMANDING FOR A HEARING

BY CHAIRMAN GOULD AND MEMBERS FOX AND BRAME

On November 17, 1997, the Regional Director issued a Notice to Show Cause as to "whether there is reasonable cause to believe that the instant petition raises a question concerning representation within the meaning of Section 9(c) of the Act on the basis that the petitioned-for primary care and specialty physicians are or are not employees within the meaning of the Act." By decision dated January 8, 1998, the Regional Director dismissed the petition in this proceeding on the ground that the petitioned-for physicians are independent contractors based on the evidence submitted by the parties pursuant to the Notice to Show Cause. The Petitioner filed a timely request for review of the Regional Director's dismissal of the petition in the absence of a hearing. Having considered the matter, including the parties' briefs on review, we have decided, for the reasons stated below, to grant the Petitioner's request for review and to remand the case to the Regional Director to arrange a hearing for the determination of whether or not the petitioned-for physicians are employees within the meaning of Section 2(3) of the Act.

The Petitioner argues that a hearing is necessary to develop the full factual context for determining the extent to which AmeriHealth monitors and controls the provision of medical care to AmeriHealth patients. It further argues that a hearing would give a fuller picture of the nature of the health care market in the era of managed care and the dependency of the petitioned-for physicians on the health maintenance organizations (HMOs) for access to patients. We find merit in the Petitioner's arguments.

The Notice to Show Cause procedure used by the Regional Director in this case is a valuable procedure designed to expedite representation cases and reduce the expenditure of resources on unnecessary hearings. While we do not wish to discourage the use of this procedure, we find that it is preferable to hold a hearing in this case, which involves an important issue of first impression and turns on a determination whether the physicians are employees or independent contractors.

The determination of whether an individual is an employee or independent contractor is not always clear-cut. In *NLRB v. United Insurance Co. of America*, 390 U.S. 254, 258 (1968), the Supreme Court observed:

There are innumerable situations which arise in the common law where it is difficult to say whether a particular individual is an employee or an independent contractor, and these cases present such a situation. On the one hand these debit agents perform their work primarily away from the company's offices and fix their own hours of work and work days; and clearly they are not as obviously employees as are production workers in a factory. On the other hand, however, they do not have the independence, nor are they allowed the initiative and decision-making authority, normally associated with an independent contractor.

The case at bar presents similar difficulties. The physicians working with HMOs maintain their own offices and staffs and are not "as obviously employees as are production workers in a factory." At the same time, the HMOs place certain conditions and restrictions on the physicians which indicate that they do not have the independence normally associated with an independent contractor. The involvement of the HMOs in the physicians' delivery of health care services and access to patients is a feature of the changing nature of the health care industry which is presented to the Board for the first time in this case. It calls into question the historical understanding of the status of physicians who maintain their own practices.

In such cases where it is difficult to determine employee or independent contractor status, the Supreme Court has stressed the necessity to assess all aspects of the relationship between alleged employee and alleged employer. In *United Insurance*, the Court stated:

In such a situation as this there is no shorthand formula or magic phrase that can be applied to find the answer, but all of the incidents of the relationship must be assessed and weighed with no one factor being decisive. What is important is that the total factual context is assessed in light of the pertinent common-law agency principles. Id.

We find that the best way for us to assess the total factual context here is to provide for the full development of the record through a hearing. In a hearing, the Board will be presented not only with the documentary evidence which was submitted in the Notice to Show Cause stage of this proceeding, but also with evidence adduced through the direct and cross-examination of witnesses. Such evidence will provide a more complete picture of the day-to-day interaction between the physicians and the HMOs and the impact of the HMOs on the physicians' access to and care of patients. It will also provide a more complete picture of the nature of the overall practices of the physicians who contract with the HMOs and the impact of managed health care in Atlantic and Cape May Counties, New Jersey, on such practices.

We stress that our decision today makes no determination on the status of the petitioned-for physicians and is not to be construed as suggesting that we would find differently on that issue than the Regional Director.¹ Instead, we find that a hearing is desirable here, where the issue of the relationship between physicians and HMOs is raised for the first time to the Board and where the determination of status relies so heavily on the full factual context of the relationship.²

DIRECTION

IT IS DIRECTED that the Regional Director's dismissal of the petition is reversed, the petition is reinstated and the case is remanded to the Regional Director for a hearing for the purpose of receiving evidence to resolve the question of whether the petitioned-for physicians are or are not employees within the meaning of the Act and the issuance of a decision.

ORDER

It is ordered that the proceeding be remanded to the Regional Director for Region 4 who shall arrange and issue the notice of hearing.

MEMBER BRAME, dissenting.

Contrary to my colleagues, I would affirm the Regional Director's attached administrative dismissal of the petition in this case. The petition seeks a unit of primary care and specialty physicians employed by the Employer in Atlantic and Cape May County, New Jersey. Following an extensive investigation and review of the voluminous submissions by the parties, the Regional Director determined that the physicians sought are independent contractors and accordingly are not employees of the Employer within the meaning of the Act.

The Regional Director found that the physicians make the fundamental decisions that determine the profitability of their practices, including whether to affiliate with one or more health maintenance organizations (HMOs). She further found that the physicians exercise total control over the expenses and staffing of their offices, hold themselves out and advertise to the public under their own name, and are not subject to any restrictions by the Employer on expanding, contracting, merging, or selling their practice. Moreover, the Employer has only a 10-percent share of the Atlantic and Cape May County HMO market and the average petitioned-for physician contracts with four HMOs in addition to the Employer. Although the Regional Director noted that the Petitioner has pointed to some factors which tend to support a finding of employee status, she found that those were overwhelmed by the factors supporting the finding that the disputed physicians are independent contractors.

My colleagues do not dispute that the Regional Director's determination is consistent with established precedent based on the facts found by the Regional Director. Nor do they find that the Petitioner has established that any of the Regional Director's factual findings are erroneous. Rather, they have granted the request for review on the grounds that a hearing will provide "a more complete picture" of the relationship between the physicians and the Employer. Accordingly, it would appear that the only purpose of the remand is to provide the Petitioner with another opportunity to present evidence favorable to its position. However, the Petitioner, as my colleagues concede, has not shown that such additional evidence exists. In these circumstances, the remand is little more than a fishing expedition for the benefit of counsel and a limited postponement of a sure and certain dismissal. In my view, a remand under these circumstances is inappropriate. Furthermore, it sends a highly misleading message to the public and our understaffed Regional Offices (the Philadelphia Regional Office, and many others, is below authorized and optimum staffing levels) that the issue is uncertain and constitutes a gross waste of our Agency's limited resources. Accordingly, I dissent.

APPENDIX

The above-captioned case petitioning for an investigation and certification of representative under Section 9(c) of the National Labor Relations Act has been carefully investigated and considered.

As a result of the investigation, I find that further proceedings are unwarranted. On October 27, 1997, the Petitioner filed a petition seeking to represent "all primary care and specialty physicians employed by AmeriHealth Corporation in Atlantic and Cape May County, New Jersey." The Petitioner contends that there are approximately 200 such individuals, while AmeriHealth states that there are nearly 600. On November 17, 1997, I issued a Notice to Show Cause as to "whether there is reasonable cause to believe that the instant petition raises a question concerning representation within the meaning of Section 9(c) of the Act on the basis that the petitioned-for primary care and specialty physicians are or are not employees within the meaning of the Act." Each party filed a response to the Notice to Show Cause with accompanying exhibits and subsequently filed a reply to the other party's response. After reviewing these submissions, I have concluded that the petitioned-for physicians are not employees of AmeriHealth within the meaning of Section 2(3) of the Act.

¹ Chairman Gould notes that the Regional Director relied on Board precedent holding that requirements imposed by governmental regulations do not constitute control by an employer, but control by the governing body. Air Transit, 271 NLRB 1108 (1984). He would overrule this precedent and return to the Board's earlier position that the critical consideration is the employer's degree of control over the means and manner in which work is accomplished, regardless of whether that control is imposed because of governmental regulations or for other business reasons. See e.g., Mitchell Bros. Truck Lines, 249 NLRB 476, 480-481 (1975), where the Board reasoned: "[W]hat is important is the actual relationship between the carriers and the drivers, and not the reason for it. . . . [I]t matters not whether the controls placed on the driver emanate from Mitchell Bros. independently, or whether these controls are imposed on Mitchell Bros., which in turn imposes them on the drivers. Either way, these controls define the carrier's employment relationship with its drivers."

² By directing a hearing in these circumstances, we do not suggest that a hearing must be directed in all future cases presenting this issue. That determination should and will be made based on the facts and circumstances of each case.

AmeriHealth operates six health maintenance organizations (HMOs) in the State of New Jersey which provide health care to the HMO members through a network of primary care and specialty physicians. Virtually all of these physicians are sole practitioners or members of group practices of varying sizes, and most of their practices are professional corporations. The physicians do not exclusively treat patients who are covered by AmeriHealth insurance. They also treat patients who are members of other HMOs, are covered by Medicare, are covered by non-HMO insurance, or pay directly for the physicians' services. AmeriHealth has a 10-percent share of the HMO market in Atlantic and Cape May counties, and the petitioned-for physicians are each affiliated with an average of 4.66 HMOs other than AmeriHealth. The Petitioner presented evidence from a primary care physician who stated that about 30 percent of his patients are insured through AmeriHealth, and that he sees 5 to 10 such patients each day. Physicians in the AmeriHealth network continue to maintain the identity of their practices, and they do business and advertise in their own names and/or the names of the group practices with which they are associated. The physicians' practices each hire and compensate their own staffs of nurses, medical assistants, and office clerical employees. Their staffs perform functions including patient billing and other paperwork, as well as the administration of certain medical procedures. Physicians also secure and maintain their own offices and obtain their own medical equipment and insurance.

In order to affiliate with AmeriHealth a physician must become "credentialed." During the credentialing process Ameri-Health interviews the physician and requires him or her to complete a detailed application packet. Among other things, the physician must demonstrate that he or she is properly licensed and maintains sufficient malpractice insurance, relevant medical board certifications, and hospital privileges. Ameri-Health also inspects the physicians' offices to ensure that they have adequate facilities, staff, and medical equipment to provide proper patient care for AmeriHealth's members. Thereafter, physicians must be recredentialed every 2 years.

Physicians who participate in the AmeriHealth network must sign a contract called a "Provider Service Agreement." The Agreement, inter alia, sets forth the physician's remuneration, requires that the physician provide medical records to Ameri-Health on request, and mandates that the physician treat AmeriHealth patients in the same manner that the physician treats other patients. The Agreement has a 1-year term, but states that it "shall continue in effect from year to year unless terminated on its anniversary date by either party by a written notice thereof." The Agreement further indicates that "each party . . . is at all times acting as an independent contractor, and that neither party has any express or implied authority to assume or create any obligation or responsibility on behalf of or in the name of the other party." The Provider Service Agreement is a standard form document, and the Petitioner has provided evidence that the terms of the Agreement, including remuneration, are generally presented to physicians as nonnegotiable. AmeriHealth has demonstrated, however, that in limited circumstances it has agreed to provide more favorable contracts and remuneration rates to physicians whose specialties are in short supply in particular geographic areas.

AmeriHealth remunerates physicians for covered services for their patients on either a "capitation" or "fee for service" basis. Under the capitation system, physicians are paid a flat monthly rate for each patient that designates them as their primary care physician. The rate per patient varies with the patient's age, but does not depend on how many times the patient actually uses the physician's services. Under the fee for service system, AmeriHealth remunerates physicians in accordance with a fee schedule that sets forth fixed amounts for each procedure or treatment performed by the physician. AmeriHealth requires primary care physicians to be paid on a capitation fee basis if they serve more than 100 AmeriHealth members; otherwise, they can choose either system. All specialty physicians are paid pursuant to the fee for service system.

AmeriHealth members are covered for specific medical services as set forth in their employers' contracts with Ameri-Health. In general, members are covered for office visits to physicians and for specified medical services "to the extent that they are medically necessary for the proper treatment of the Member's Condition." Numerous medical services are excluded from coverage, such as in vitro fertilization, comfort and convenience items at hospitals, and hearing aids. Health's Provider Manuals set forth various rules and procedural requirements for participating primary care and specialty physicians. Among other things, these manuals list numerous medical services that require "precertification" by Ameri-Health, and AmeriHealth will not pay physicians for these services absent precertification. In order to secure precertification of services as medically necessary, the physicians and their staffs often must provide considerable information to Ameri-Health, and the process may require repeated telephone calls. In determining whether services are medically necessary, AmeriHealth representatives rely in part on the Optimed Medical Appropriateness Screening Criteria, a computer software program based on national standards. AmeriHealth also requires that its members receive medical tests only at specified approved laboratories. Physicians also must obtain preapproval for all surgery and referrals to specialty physicians who are not part of the AmeriHealth network, as well as for hospital inpatient care. AmeriHealth must approve the hospital to which the member is referred and the length of the stay. Additionally, AmeriHealth requires physicians to complete and forward various forms within specified time limits in order to receive payment for their services. Petitioner submitted evidence indicating that some physicians and their office staffs have found the process of securing preapproval to be time-consuming and frustrating.

If an AmeriHealth representative denies approval for a member to receive a requested service, the physician and the mermber may appeal the denial through several levels pursuant to a written appeals procedure. From January 1, 1996, through December 5, 1997, only two denials were formally appealed through this process, and one of these appeals was upheld. The Petitioner provided considerable evidence that physicians have submitted claims for payment to AmeriHealth for services that AmeriHealth declined to reimburse. One specialty care physician, for example, had reimbursement claims denied because of failure to obtain precertification for the service or to receive a referral from a primary care physician. He also was not paid by AmeriHealth for services he provided that AmeriHealth deemed ineligible for reimbursement. The physician did not collect payments from AmeriHealth or the involved patients for those services, which resulted in his "writing off" \$77,665 of the \$102,295 that he billed AmeriHealth during an unspecified time period.

AmeriHealth does not permit physicians to charge its members directly for services covered by AmeriHealth (a practice called balance-billing), but they may charge such patients for services that are not covered. AmeriHealth requires primary care physicians, under the capitation arrangement, to provide physical examinations and medical services such as inoculations to covered members in certain circumstances pursuant to a specified schedule. According to Petitioner, AmeriHealth has at times increased these requirements without providing additional payments to the physicians.

Under the Provider Service Agreement, physicians are required to participate in AmeriHealth's Quality Management Program. Pursuant to this program, AmeriHealth is permitted to inspect physicians' offices "upon reasonable notice and at reasonable hours." Among other things, AmeriHealth representatives appraise the condition of the waiting room and medical equipment and evaluate the attitude of the staff. They also review physicians' records to determine how many patients they see each day, as well as the average waiting time for patients. AmeriHealth has issued Standards of Service to physicians, which, inter alia, require them to limit waiting time for covered patients to 30 minutes and to set appointments with covered patients during specified time frames. For example, primary care physicians should provide AmeriHealth members with "emergent" care immediately, "urgent" care within 24 hours, and routine appointments within 2 weeks. The Standards of Service also state that the physicians' practices should schedule at least one evening or weekend session per week, and that physicians must provide members with access to care 24 hours per day, 7 days a week by an AmeriHealth network provider. AmeriHealth also regularly inspects its members' records, and physicians must provide these records to Ameri-Health representatives on request. AmeriHealth reviews the members' records for legibility and completeness. After inspecting the physicians' records and offices, AmeriHealth provides them with verbal and written evaluations and appraisals which include comparisons with other physicians.

The New Jersey HMO Act and related administrative regulations mandate many of the procedural and credentialing requirements that AmeriHealth imposes on its participating physicians. Thus, the State requires that HMO physicians assure 24-hour-a-day, 7-day-a-week coverage for patients, treat patients with courtesy and consideration and respect for dignity and privacy, and maintain proper licenses, hospital staffing privileges, and adequate malpractice coverage. New Jersey further requires that HMOs have a right of access to the physicians' medical records and maintain continuous quality improvement programs that specify standards of care and procedures for assessing the quality of medical services. HMOs also must be audited every 3 years by an "external quality review organization" approved by the State. Pursuant to this regulation, AmeriHealth has been audited by the National Committee for Quality Assurance (the NCQA), an independent organization that is partially funded by HMOs. The NCQA requires that the HMO maintain guidelines concerning matters such as patient waiting time and appointment availability, but it does not specify what these guidelines should be. The NCQA also mandates that as part of the credentialing process an HMO representative visit each primary care physician, obstetrician/gynecologist, and high-volume specialist and review the physical appearance and accessibility of the office, availability of appointments, and maintenance of patient confidentiality. Additionally, the NCQA requires that physicians be recredentialed by the HMO every 2 years, and that the recredentialing process include an office visit.

Section 2(3) of the Act excludes from the definition of "employee," any individual having the status of an "independent contractor." In NLRB v. United Insurance Co. of America, 390 U.S. 254 (1968), the Supreme Court held that the proper standard in distinguishing employees from independent contractors under the Act is the common law of agency. This standard looks to whether the person for whom the services are performed reserves the "right to control" not only the ends to be achieved, but also the means to be used in achieving those ends. Operating Engineers Local 487 Health & Welfare Trust Fund, 308 NLRB 805 (1992), and News Service Syndicate Co., 164 NLRB 422, 423-424 (1967). In Standard Oil Co., 230 NLRB 967, 968 (1977), the Board set forth the following factors in connection with the common law right to control test as significant in determining whether an employment relationship exists: (1) whether individuals perform functions that are an essential part of the company's normal operation or operate an independent business; (2) whether they have a permanent working relationship with the company which will ordinarily continue as long as performance is satisfactory; (3) whether they do business in the company's name with assistance and guidance from company personnel and ordinarily sell only the company's products; (4) whether the agreement which contains the terms and conditions under which they operate is promulgated and changed unilaterally by the company; (5) whether they account to the company for the funds they collect under a regular reporting procedure prescribed by the company; (6) whether particular skills are required for the operations subject to the contract; (7) whether they have a proprietary interest in the work in which they are engaged; and (8) whether they have the opportunity to make decisions which involve risks taken by the independent business person which may result in a profit or loss. No single factor is determinative; each case must be analyzed as to all of its circumstances. Air Transit, Inc., 271 NLRB 1108, 1110 (1984), and Seafarers Local 777 (Yellow Cab) v. NLRB, 603 F.2d 862, 872-873 (D.C. Cir. 1978). A written agreement defining the relationship as one of "independent contractor" may be given weight but is not dispositive. See, e.g., Big East Conference, 282 NLRB 335, 345 (1986), affd. sub nom. Collegiate Basketball Officials Assn. v. NLRB, 836 F.3d 143 (3d Cir. 1987). Finally, the Board has consistently held that requirements imposed by governmental regulations do not constitute control by an employer, but control by the governing body. Elite Limousine Plus, 324 NLRB 992, 993-995 (1997), and Air Transit, supra at 1110.

Application of these factors convincingly demonstrates that the petitioned-for physicians are independent contractors rather than employees. Most significantly, the physicians themselves make the fundamental decisions that determine the profitability of their practices. Thus, they retain the unfettered right to decide matters as basic as whether they will be sole practitioners or enter into a group practice and whether to become affiliated with one or more HMOs. In fact, AmeriHealth physicians generally contract with several HMOs that directly compete with AmeriHealth and each other. Physicians spend only a minority of their work time and derive a minority of their income from service to AmeriHealth members. See *Young & Rubicam International*, 226 NLRB 1271, 1276 (1976). The physicians

have virtually total control over their expenses. Thus, aside from the minimum equipment and waiting room size prescribed by AmeriHealth, the physicians determine the locations, contents and cost of their offices, and they make significant capital investments in their medical and office equipment. See, Young & Rubicam International, Inc., supra; City Cab Co. of Orlando, 285 NLRB 1191, 1194 (1987). They also determine the number of staff members to employ and their compensation, and they retain full supervisory authority over their employees. The physicians also can substantially affect their incomes. In this regard, AmeriHealth pays physicians a flat rate under both the capitation and fee for service systems. Therefore, the physicians' professional judgment and efficiency will strongly influence their practices' profitability. See Young & Rubicam, supra; Boston After Dark, Inc., 210 NLRB 38 (1974). Moreover, AmeriHealth plays no role in setting physicians' work hours other than requiring the practices to operate one night or weekend day per week, and AmeriHealth does not limit the number of patients that physicians can see. Considering that the physicians determine their expenses and can vary their incomes, it is clear that the physicians retain considerable control over their earnings. See, e.g., Big East Conference, supra at 345. AmeriHealth also does not provide fringe benefits, vacation, or sick leave to physicians, nor make any deductions from the physicians' remuneration. See Cardinal McCloskey Children's & Family Services, 298 NLRB 434, 435 (1990). Significantly, physicians have a full proprietary interest in their practices; there is no evidence that AmeriHealth can restrict them from expanding, contracting, or selling their practices or that it controls the organization and management of the work performed in the physicians' practices. Moreover, physicians' medical practices hold themselves out to the public and advertise themselves under their own names rather than doing business in AmeriHealth's name. All of these factors convincingly demonstrate that the physicians are independent contractors.

I recognize that there are some factors which would tend to support a finding of employee status. For one, AmeriHealth's contracts with physicians are not generally subject to negotiation. Additionally, the physician's affiliation with AmeriHealth by the terms of the contract continues indefinitely absent a decision by either party to terminate the relationship. Moreover, the physicians' contracts with AmeriHealth unquestionably subject them to a variety of restrictions and procedures that they would not face absent affiliation with an HMO. Thus, in order to be paid for performing various medical services that they deem necessary, or to refer AmeriHealth patients for hospitalization, the physicians' offices must first obtain precertification from AmeriHealth. They are also subject to credentialing and Quality Management Program requirements which

include inspections of their offices and records. The physicians' offices must maintain frequent contact with AmeriHealth concerning medical as well as procedural matters, and they regularly complete forms and submit them to AmeriHealth in order to receive payment. Some of AmeriHealth's procedural requirements are mandated or inspired by State law, however. Others are an attempt to comply with the NCQA standards and NCQA's auditing process is required by State law. As noted above, to the extent that restrictions are required by State law, the Board does not treat them as mandated by the purported employer.

On balance, I find that the factors favoring a finding of employee status for the particular physicians at issue here are substantially outweighed by those favoring a finding of independent contractor status. In my view, the physicians who participate in AmeriHealth's HMOs are skilled professionals who retain the characteristics of independent business persons. Based on the above, I find that the petitioned-for physicians are not employees of AmeriHealth but are independent contractors. *Big East Conference*, supra; and *Young & Rubicam*, supra. Accordingly, I am withdrawing the notice of hearing previously issued, and I am dismissing the petition in this matter.

Pursuant to the National Labor Relations Board's Rules and Regulations, you may obtain a review of this action by filing a request therefor with the National Labor Relations Board, addressed to the Executive Secretary, National Labor Relations Board, Washington, D.C. 20570. A copy of such request for review must be served on the Regional Director and each of the other parties to the proceeding. This request for review must contain a complete statement setting forth the facts and reasons on which it is based. The request for review (eight copies) must be received by the Executive Secretary of the Board in Washington, D.C. by the close of business on January 22, 1998. Upon good cause shown, however, the Board may grant special permission for a longer period within which to file. The request for extension of time should be submitted to the Executive Secretary of the Board in Washington, D.C., and a copy of any such request for extension of time should be submitted to the Regional Director, and to each of the other parties to this

The request for review and any request for extension of time for filing must include a statement that a copy has been served on the Regional Director and on each of the other parties to this proceeding, and the copy must be served in the same or faster manner as that utilized in filing the request with the Board. When filing with the Board is accomplished by personal service, however, the other parties shall be promptly notified of such action by telephone, followed by service of a copy by mail or facsimile transmission.